Central Orthotic & Prosthetic Company, Inc.
Patient Registration (Please Print Clearly)

Patient's Legal Name: _____ _____ _____

First Name ***MI*** ***Last Name*** ***Social Security Number***

Date of Birth: _____ ☐ Male ☐ Female ☐ ☐ Single ☐ Married ☐ Widowed ☐ Divorced Separated

Street Address **with Apt/Unit/Space #**: _____

City/State/Zip Code: _____ Home Phone: (____) _____

Cell Phone: (____) _____ Fax Number: (____) _____

Spouse's Name: _____ Social Security #: _____

Patient's Employer: _____ Work Phone #: (____) _____

Responsible Party: _____

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Patient is a Minor, are parent ☐ Married ☐ Divorced ☐ Custodial Parent: _____

Custodial Parent's Home Phone: (____) _____ Work Phone #: (____) _____

Custodial Parent's Social Security #: _____ Date of Birth: _____

In case of emergency, contract (not living with you): _____

Phone Number: (____) _____ Relationship to Patient: _____

☐ ☐

Is this work-related? Yes No If yes, date of injury? _____ Claim #: _____

How did this injury happen? _____

_____

_____

Referring Physician's Name & Phone Number: _____

Physician Name and Phone Number Caring for Diabetes: _____

Please Present Insurance Card(s) For Copying and Complete the Requested Information

Insurance Company #1: _____ Phone Number: (___) _____

Primary Insured's Name:_____ Date of Birth:_____

Policy Number:_____ Group:_____ Relationship:_____

Insurance Company #2:_____ Phone Number: (___)_____

Primary Insured's Name:_____ Date of Birth:_____

Policy Number:_____ Group:_____ Relationship:_____

If you do not have insurance, have you applied for Medical Assistance? ☐ Yes No If yes, what is the name and phone number of the social worker with whom you are working?_____

- I hereby authorize the payment of medical benefits to Central Orthotic & Prosthetic Company, Inc. for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of nay amounts outstanding.
- I hereby authorize Central Orthotic & Prosthetic Company, Inc. to release any medical information necessary to complete and process my insurance claims.

_____ _____

Patient's OR Insured's Signature (If patient is a Minor, must have a Responsible Party Signature) Date

I authorize Central Orthotic & Prosthetic Company, Inc. to treat and use my personal health information for healthcare operation.

_____ _____

Patient's Signature (Or Parent if patient is a Minor) Date

Following sets forth the general billing policy of Central Orthotic & Prosthetic Company, Inc. Please review the information and sign where indicated.

- I understand that it is my responsibility to provide the office of Central Orthotic & Prosthetic Company, Inc. with current, accurate billing information at the time of check in and to notify CENTRAL ORTHOTIC & PROSTHETIC COMPANY, INC. of any changes in this information.
- I understand that it is my responsibility to know my special copay (which is different than my Primary Care copayment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that CENTRAL ORTHOTIC & PROSTHETIC COMPANY, INC. also has a contractual agreement with my health plan to collect copays at the time of service.
- I understand that CENTRAL ORTHOTIC & PROSTHETIC COMPANY, INC. will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any services that I may have. I further understand that it is CENTRAL ORTHOTIC & PROSTHETIC COMPANY, INC.'s policy to collect the deductible and/or coinsurance on delivery. I further understand that THE FEE I AM QUATOED IS AN ESTIMATE based on 1) anticipated services to be rendered and 2) current information provided to CENTRAL ORTHOTIC & PROSTHETIC COMPANY, INC. by my insurance carrier.
- I understand that CENTRAL ORTHOTIC & PROSTHETIC COMPANY, INC. will bill me for any amounts due by me (copayments/coinsurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that CENTRAL ORTHOTIC & PROSTHETIC COMPANY, INC. will provide me with two (2) statements for ay balance due after insurance payment. I further understand that

if I have not made payment prior to the second statement being mailed, that the second statement will be marked as “Final Notice” and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

- I understand that CENTRAL ORTHOTIC & PROSTHETIC COMPANY, INC. will obtain the necessary prior authorization prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, ad that I am responsible for any bills not paid by my insurance carrier.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the practitioners of Central Orthotic & Prosthetic Company, Inc.

_____ _____

Legal Signature ***Date***

_____ _____

Relationship to Patient ***Patient’s Name***